Commonwealth of Massachusetts
Board of Registration in Medicine

Annual Report to the General Court and the Special Commission on Medical Malpractice

Calendar Year 1989

Commonwealth of Massachusetts
Board of Registration in Medicine

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Commonwealth of Massachusetts
Board of Registration in Medicine
Ten West Street, Third Floor
Boston, Massachusetts 02111
(617) 727-3086 Licensing Unit
(617) 727-1788 Disciplinary Unit
(617) 727-0303 Patient Care Assessment Unit

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INTRODUCTION

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The Board of Registration in Medicine has a dual function in protecting the public: it sets standards for qualification to be licensed as a physician or acupuncturist in the Commonwealth; and, it investigates and takes disciplinary action against physicians and acupuncturists who engage in malpractice or misconduct. Both of these functions are important in ensuring that only competent physicians and acupuncturists practice in Massachusetts. In 1986, the Medical Malpractice Reform Act provided the Board with more avenues by which to investigate complaints, discipline problem physicians and maintain a high quality of patient care and medical practice statewide. In response to the Act, the Board created a malpractice prevention program called Patient Care Assessment that was the first of its kind in the nation. In addition to requiring that health care providers report substandard care to the Board, the Act directed the Board to receive all medical malpractice and disciplinary data through a central bank called the Data Repository.

The Board's highest priority is to foster competent, high quality health care in Massachusetts. **Prevention** is the key aspect of the Board's programs. The Board continually searches for ways to educate physicians about their legal responsibilities to patients. One of the Board's major initiatives in 1989 was the adoption of **Prescribing Practices Policy and Guidelines**, to promote proper prescribing practices by physicians, rather than merely punish infractions after the fact. The Board believes that this Guide will advance that goal by giving physicians a clear understanding of the standards the Board applies in reviewing their prescribing practices. Many of the provisions of the Guide also address the problem of drug diversion.

In its **Chemically Dependent Physician Policy**, the Board clearly stated that its primary goal of protecting public safety is best served by encouraging chemically dependent physicians to seek and receive treatment as early as possible. The Board is committed to assisting chemically dependent physicians toward recovery with the Board's support. To that end, the Board took three major steps in 1989. 1) The Board secured passage of legislation to exempt participation in chemical dependency treatment programs from mandatory reporting requirements under

appropriate circumstances. 2) In recognition of the denial that occurs in chemical dependency, the Board adopted an **Amnesty Policy** for erroneous and misleading information physicians reported on past license renewal applications. 3) The Board sponsored a **Conference on Chemical Dependency in Medicine** for individuals from health care facilities, medical schools and other health-related licensing boards from Massachusetts and surrounding states.

During the past year, the Board has been assisting medical specialty societies in the development of practice standards or guidelines. The Board produced and mailed a brochure, entitled *Developing Medical Specialty Standards: A Guide for Specialty Societies*, to every specialty society in the state. The Board recognizes that standards developed and implemented by practitioners for their own specialties have the potential to reduce or stabilize malpractice losses in many fields of medicine. To help realize this potential, the Massachusetts Division of Insurance, which sets and establishes medical malpractice premium rates, is empowered to grant a discount on malpractice premiums for the adoption of standards designed to reduce losses. This discount is an incentive to encourage physicians to undertake the time-consuming effort of identifying problems in practice and introducing corrective measures. Two specialties, anesthesiology and emergency medicine, have already been granted 20 percent malpractice insurance premium discounts for their programs.

The Board played an active role in the activities of the **Massachusetts House of Representatives Committee on Sexual Misconduct by Physicians, Therapists and other Health Professionals**.

The Board supported legislation before the Joint Committee on Health Care which would create a Multiple Copy Prescription Program in the Commonwealth. Such programs have been very successful in reducing prescription drug abuse and diversion in other states and could have a major impact on the drug diversion problem in this state.

The Board also supported legislation before the Joint Committee on Human Services and Elderly Affairs which would require the Board to print on all license application forms a statement of understanding and knowledge of the duty to report child abuse, neglect, and sexual abuse. The

Human Services Committee's Special Subcommittee on Foster Care commended the Board for its support of this important legislation.

Organization of the Board

The Board consists of five physicians and two public members appointed by the Governor to three-year staggered terms (See Attachment A). The Board meets at least twice monthly to decide licensing, disciplinary, regulatory and administrative matters. The members also routinely work with staff to offer direction in the processing of disciplinary cases, license applications, mandated reporting and Patient Care Assessment compliance.

Acknowledgements

The sound direction, advice and assistance of many groups and individuals helped the Board accomplish many of its major initiatives in 1989. Special recognition is due the experts who served on the **Working Group** that advised the Board in the development of the **Prescribing Practices Policy and Guidelines**. These experts were from the Massachusetts State Police, Diversion Investigative Unit; the Federal Drug Enforcement Administration; the Massachusetts Department of Public Health, Division of Food and Drugs; the Board of Registration in Pharmacy; the Mini-Residency in the Proper Prescribing of Controlled Dangerous Substances at the University of Medicine and Dentistry of New Jersey; and the Massachusetts Medical Society's Committee on Public Health.

As it has in the past, the Medical Society's Committee on Physician Health and the Committee on Drug and Alcohol Dependency (CDAD) of the Massachusetts Dental Society offered invaluable assistance on our **chemical dependency issues**.

Special recognition also must be given to the important work being done by the members of the **Massachusetts House of Representatives Committee on Sexual Misconduct by Physicians, Therapists and other Health Professionals** and, in particular, the following House of Representatives Members: Representative Barbara Gardner, Chairman; Representative John C. Bartley; Representative Larry F. Giordano; Representative Barbara E. Gray; and Representative Christopher J. Hodgkins. The Board also would like to give special recognition to the fine efforts of

a newly formed self-help group called **Therapy Exploitation Link Line (TELL)**, which helps victims of sexual abuse by therapists and other health professionals.

Special thanks goes to **MASSPIRG, Public Citizen Health Research Group** and the **American Association of Retired Persons (AARP)** for their sound advice.

The **Joint Education Committee** (a joint Board and teaching hospital committee) and the **Advisory Panel on Refugee Physicians** have offered invaluable advice to the Board on licensing matters.

Physicians serving on the Board's **Medical Expert Advisory Panel on Disciplinary Matters** provided invaluable assistance on the Board's disciplinary cases.

The Department of Public Health and many interested parties, representing elder constituents and long-term care facilities, provided invaluable guidance in the development of the Nursing Home PCA regulations.

The Board would like to commend the **presidents of the medical specialty societies** for their important work on developing medical specialty standards.

The chairmen of the Joint Committee on Health Care, Senator Edward L. Burke and Representative John C. McNeil, the chairmen of the Committees on Ways and Means, Senator Patricia D. McGovern and Representative Richard A. Voke, the chairmen of the Special Commission on Medical Malpractice, Senator Linda J. Melconian and Representative Francis H. Woodward, the Committee members and their staffs deserve recognition for their leadership on many issues affecting the Board.

The Board also deeply appreciates of the support and guidance of Governor Michael S. Dukakis, former Consumer Affairs Secretary Paula W. Gold and the Legislature. The Board looks forward to working with Secretary Mary Ann Walsh on important issues in 1990.

I. MAJOR INITIATIVES IN 1989

Prescribing Practices Policy and Guidelines

On May 3, 1989, the Board adopted *Prescribing Practices Policy and Guidelines*. The 150-page Policy was prepared to provide physicians with a greater understanding of their responsibilities for controlled substances.

The Policy is in two parts. The first part summarizes the federal and state laws regarding the prescribing of drugs, and includes Board and Court interpretations of these laws. The second half addresses specific topics, such as treating drug dependent persons and the management of pain. Additionally, it lists 20 specific guidelines developed to help physicians in daily prescribing situations.

Assisting the Board in developing the Guidelines were experts from the Massachusetts State Police, Diversion Investigative Unit; the Federal Drug Enforcement Administration; the Massachusetts Department of Public Health, Division of Food and Drugs; the Board of Registration in Pharmacy; the Mini-Residency in the Proper Prescribing of Controlled Dangerous Substances at the University of Medicine and Dentistry of New Jersey; and the Massachusetts Medical Society's Committee on Public Health.

The new prescribing requirements include:

Ban on Anabolic Steroids for Athletic Purposes: The use and distribution of steroids is illegal in the United States, except through authorized prescriptions. While there are many positive uses for steroids which are clearly medically appropriate, the practice of prescribing anabolic steroids for the sole purpose of increasing a patient's body muscle and/or athletic performance is questionable.

Anabolic steroids appear to be effective at hastening muscle growth, increasing strength and adding bulk. These benefits, however, may come at a significant price. Potential side effects are extremely severe, and include liver cancer, high blood pressure, clogging of the arteries, hypertension, prostate cancer, breast cancer and sterility.

Major athletic organizations, including the National Collegiate Athletic Association, the International Olympic Committee, the National Football League, and Major League Baseball, already ban the use of anabolic steroids in their sports. In June, 1988, the American Medical Association issued a resolution condemning the use of anabolic steroids for athletic purposes and urging states to pass laws against such use.

Consequently, the Board has adopted a regulation which prohibits the prescription of anabolic steroids for the purpose of enhancing a patient's athletic ability or performance. Violators may be subject to Board disciplinary sanctions.

Ban on Anorectic Appetite Suppressants (Amphetamines and Sympathomimetic Amines) for Weight Control Purposes: Anorectics have some accepted uses, including use in the treatment of properly documented Attention Deficit Disorder or Hyperkinetic Syndrome in children and narcolepsy or idiopathic CNS hypersomnia in adults. Anorectics are also frequently used as appetite suppressants. However, serious questions have been raised about their clinical effectiveness in treating weight problems. There are also strong indications that many patients may achieve more successful results through modern behavior modification techniques than through drug therapies involving the prescription of anorectics. The questionable effectiveness of anorectics is especially troublesome because anorectics have a substantial potential for inducing dependence and are frequently the subject of misuse. A substantial number of Board disciplinary cases having to do with improper prescribing practices have involved the prescription of anorectics. Consequently, the Board promulgated a regulation which prohibits the prescription of anorectics (amphetamines and sympathomimetic amines) as an appetite suppressant.

No Schedule II Prescribing to Immediate Family Members, which includes a Spouse or Equivalent, except in emergency situations: Physician prescriptions to immediate family members is frequently associated with problems of self-medication and physician chemical dependency and is therefore carefully scrutinized by the Board. Treatment of immediate family members with controlled substances over a substantial period of time may indicate a lack of

in question is in compliance with the requirements of a drug or alcohol program satisfactory to the Board, or has successfully concluded such a program subsequent to the actions or circumstances requiring the reporting.

Board Adopts Amnesty Policy for License Renewals Filed by Chemically Dependent Physicians

On August 2, 1989, the Board adopted an **Amnesty Policy** for license renewals filed by chemically dependent physicians. The Policy concerns information physicians reported on past license renewal applications.

Consistent with the Board's *Chemically Dependent Physician Policy* adopted on June 15, 1988, the Board encourages physicians engaging in substance misuse to seek assistance and to report their problems voluntarily to the Board. There may be physicians who are presently in recovery and would like to report their chemical dependency to the Board, but who, when completing past renewal applications, provided an untruthful or otherwise incorrect answer to a question the Board has asked in the past: "Are you now, or have you been in the past, dependent upon alcohol or drugs?"

As a transitional measure to encourage physicians who wish to take advantage of the Board's *Chemically Dependent Physician Policy*, but who are concerned about their answers on past renewal applications, the Board has adopted an **Amnesty Policy**.

The Policy is as follows: The Board will not commence disciplinary proceedings, for filing a false renewal application, against a physician who files an amendment to his or her past renewal applications, provided that:

(1) The amendment must be postmarked (under a recent extension) no later than December 31, 1990.

(2) The amendment must relate to the question dealing with drug- or alcohol-related dependency or impairment only (Question 22 on the 1987-89 and 1989-91 renewal applications). Note, for

example, that this is not an "amnesty" for patient harm a physician caused while drug- or alcohol-impaired.

(3) The amendment (like the original renewal application) is signed under the pains and penalties of perjury.

(4) The corrected renewal application can relate back to correct false information as to drug or alcohol misuse provided on an initial license application completed before June 15, 1988.

(5) This Policy does not include other false or incorrect answers. For instance, if alcohol-dependency was the alleged cause of the physician's involvement in a criminal proceeding, and the physician did not disclose the criminal proceeding in answering Question 16, then the false answer to Question 16 is beyond the scope of this **Amnesty Policy**.

(6) Upon submission of corrected information, the physician shall be subject to the same Board policies and procedures that would be applicable if correct information had been provided to the Board initially.

Specialty Standards

During the past year, the Board has assisted medical specialty societies in the development of practice standards or guidelines and produced and mailed a brochure, *Developing Medical Specialty Standards: A Guide for Specialty Societies*, to every specialty society in the state. The brochure describes how a specialty's closed malpractice claims can be reviewed to identify patterns of practice that fall below accepted norms or are amenable to cost-effective improvements that can help physicians avoid practices that may compromise patient care and lead to malpractice claims.

The brochure explains how to prepare for a closed-claim study (including forming a committee, reviewing relevant publications and designing a data retrieval instrument), how to conduct the study, and how to develop the standard. A closed-claim study will involve working with the Medical Malpractice Joint Underwriting Association of Massachusetts (JUA), as well as

with the Massachusetts Division of Insurance, if the society plans to seek a medical malpractice insurance discount. The Board will assist in the coordination of these efforts.

Standards governing the practice of anesthesiology, currently referenced in the Board's regulations, serve as a model of what a specialty group can do. These standards, as further developed during the JUA rate-setting process, prompted the Insurance Commissioner to approve an insurance premium discount of 20 percent to qualifying Massachusetts anesthesiologists. The standards have led to a genuine reduction in adverse incidents. In 1988, the JUA did not record a single hypoxic injury lawsuit. The insurer credits this development to effective implementation of the standards.

As a result of a recent decision by the Insurance Commissioner that becomes effective for the policy year beginning July 1, 1990, Medical Malpractice Joint Underwriting Association (JUA) insured emergency physicians who successfully complete each element of a risk management program developed by the Massachusetts Chapter of the American College of Emergency Physicians (MACEP) will be awarded a 20% malpractice insurance premium discount.

Summary of New Regulations

In addition to the prescribing regulations mentioned above, the Board promulgated the following regulations in 1989:

Regulation Encouraging Enrollment in Drug and Alcohol Programs: The Board promulgated regulations implementing the 1989 "snitch law" amendment exempting health care providers from filing a report on drug or alcohol misuse by a physician, if the physician is participating in a drug or alcohol program satisfactory to the Board. Under the regulation, the Board issued criteria for satisfactory programs and for compliance with the exception for reports.

New Regulation Facilitates Rotation of Residents and Fellows: On April 28, 1989, the Board eased a previous regulation so that residents and fellows with limited licenses may now rotate between teaching hospitals with three or more ACGME-accredited programs without prior approval of the Board for up to eight weeks in any single year of residency.

Medical Records Retention Increased from 3 to 7 Years: Effective January 1, 1990, medical records must be maintained for seven years from the date of the last patient encounter, or until the patient reaches the age of nine (if longer than seven years). The records must be maintained in a manner which permits the former patient or a successor physician access to them within the terms of the regulations.

Establish Maximum Fees for Providing Medical Records: The regulation also provides parameters as to reasonable fees for such records. A fee for copying in excess of $.25 per page or a fee for clerical work in excess of $20 per hour is presumptively unreasonable. Charges for copies of x-rays and similar documents not reproducible within the office setting shall be at the licensee's actual cost, plus reasonable clerical fees.

Regulation Prohibits a Physician with a Revoked License from Holding Himself or Herself out as M.D., D.O., Physician, etc.: The Board is very concerned about physicians whose licenses have been revoked and who have continued to practice "psychotherapy"--an unlicensed profession. The new regulation states: "A person who holds himself out to the public as a "physician" or "surgeon," or with the initials "M.D." or "D.O." in connection with his name, and who also assumes responsibility for another person's physical or mental well-being, is engaged in the practice of medicine."

Nursing Home PCA Regulations: New Nursing Home Patient Care Assessment regulations became effective July 7, 1989. The regulations amend medical care quality standards applicable to licensed nursing homes. They require the review of professional competence of nursing home medical directors and advisory physicians, nursing home reporting of physician disciplinary actions to the Board, and the reporting of specified major adverse incidents to the Board. The Board is permitted to monitor compliance with its regulations. The types of incidents reported under the regulations were jointly determined by the Board and the Department of Public Health (DPH). The regulations were promulgated after discussions with interested parties representing elder constituents and long-term care facilities.

The Board plans to distribute a plain-English description of the new regulations to all nursing homes. The Board will join DPH in producing programs across the state on the new regulations and other changes affecting nursing homes.

Professional Corporations: The new regulation states that with respect to the licensee's practice of medicine, he or she may not limit liability for intentional torts or negligence through incorporation under chapter 156B or other form of incorporation. (This is not a change in the law; it is a clarification in response to questions the Board has received.)

Reporting of Non-Renewal of Privileges: This regulation amends the "disciplinary action" definition so that a non-renewal or restriction of privileges by a health care facility is reported to the Board only if related to competence or a complaint. The new regulation treats the non-renewal or restriction as the Board's current regulations treat resignations.

Failure to Complete Medical Records: This regulation amends the "disciplinary action" definition to require reporting of medical records violations only if tied to competence, a violation of law or a violation of a Board regulation.

Mental/Physical Exam Credentialing: This amends the mental/physical exam credentialing regulation to specify who can request an exam when a health care facility credentials its physicians.

Fraudulent Automobile Accident Medical Treatment and Billing: On April 28, 1989, the Board promulgated a regulation dealing with excessive medical treatment and fraudulent billing in automobile accident cases. The Board's regulation applies to any physician who knowingly and willfully provides excessive treatment or issues excessive bills to a patient to permit the patient to incur medical expenses in excess of the tort threshold (described below). Violation of the regulation will result in suspension of his or her license for a period of not less than one year, unless the Board finds unusual and extenuating circumstances which would warrant a lesser sanction. Excessive treatment includes treatment that exceeds the medical needs of the patient, is unrelated to the diagnosis of an injury or reasonably suspected possible injury incurred in

care facilities, medical schools and other health-related licensing boards from Massachusetts and surrounding states.

Former Consumer Affairs Secretary **Paula W. Gold** welcomed the attendees and introduced **Governor Michael S. Dukakis**. Board Chairman **Andrew G. Bodnar, M.D., J.D.** described the first year of experience with the Board's *Policy*. Other participants included Dental Board Member, **Alfred C. Peters, D.M.D., C.A.C., M.S.W.**; Director of a Continuing Care Program in Georgia, **M. Truett Bridges, Jr., M.D.**; Chairman **Bernard Levy, M.D.** and Member **Michael S. Palmer, M.D.** of the the Medical Society's Committee on Physician Health; University of Massachusetts Medical Center's Committee on Physician Health and Well-Being Member, **Jane C. Sargent, M.D.**; Nursing Board Member, **Yolanda H. Fahey, R.N., B.S.N.**; and Nurse Recovery Program Coordinator, **Sheila Lee, R.N., M.S.N.** They discussed the approach that other medical professions and organizations take to chemical dependency.

Chemical dependency affects all health professions. The solution involves hospitals, medical schools and professional societies, as well as state licensing boards. The Board's *Policy* emphasizes non-punitive measures to promote the rehabilitation of physicians who are dependent on drugs and alcohol. It has been heralded as a national model which other state licensing boards are studying in their efforts to strike a balance between their responsibility to protect the public and the need for compassionate and pragmatic approaches to help chemically dependent physicians back into active practice.

Fifth Annual Conference on Improving Disciplinary and Licensing Procedures

For the fifth year, the Board sponsored a **Conference on Improving Disciplinary and Licensing Procedures**. Twelve State Medical Boards attended the Conference in October, 1989. Boards as far away as Puerto Rico, Iowa and South Carolina attended the three-day conference which was combined with the Administrators in Medicine Society (AIMS) Regional Meeting. AIMS consists of Executive Directors and key staff personnel of all State Medical Boards. It shares and distributes among its members information, procedures, policies and techniques necessary to

and the Virgin Islands, and eleven of the sixteen independent state boards of osteopathic medicine.

Committee Participation

During 1989, important work was done to address the issue of sexual misconduct. The Board serves on the **Massachusetts House of Representatives Committee on Sexual Misconduct by Physicians, Therapists and other Health Professionals**. The Committee was established in 1989 for the purpose of making an investigation and study of the sexual misconduct of physicians, therapists and other health professionals in the course of their professional duties. The Committee is composed of concerned legislators, members of the Administration, victims, physicians and therapists, health professionals, lawyers, and representatives of professional societies. The Board is represented on the following subcommittees: Education, Victim, Criminal/Civil Statutes, Professional Society and Boards of Registration.

The Board also participated in the Secretariat's **Board of Registration Sexual Misconduct Review Group**.

The Board continued to serve on the **Coordinating Committee on House Staff Training Issues of the Massachusetts Academic Medical Centers** which is working on implementation of guidelines for medical resident hours and training.

The Board continued to serve on the **Interagency Drug Enforcement Group** consisting of state and federal agencies concerned about drug diversion.

To assist the Department of Public Health in the planning and development of the triplicate prescription program, the Board is a member of the **Triplicate Prescription Program Advisory Board**. Over the past several years the Board has consistently supported legislation calling for the establishment of a triplicate prescription program. The Department of Public Health is using two avenues to implement a triplicate prescription program -- legislation and the regulatory route.

The Board also participated in a multi-agency group which focused on physician supply problems in certain specialties and geographic regions of the state.

In November, 1989, the Board participated in a meeting with the American Cancer Society and interested parties to establish a **Cancer Pain Initiative** in Massachusetts. The Board will serve on the Executive Committee that will be working on implementation of the initiative.

III. DISCIPLINARY ACTIVITIES

The majority of physicians in the Commonwealth are competent and caring individuals who abide by the laws of the Commonwealth and the Board's regulations. For that small minority of physicians who, for whatever reason, are unable to maintain acceptable standards of medical practice, the Board imposes disciplinary sanctions to protect the public health, safety and welfare. The Board is required by law to investigate all complaints relating to the practice of medicine by its licensees. It is also authorized to investigate potential license violations which come to the Board's attention through other means. The staff of the Disciplinary Unit meet regularly with Board Members serving on the Complaint Committee. The Complaint Committee reviews alleged license violations and makes recommendations to the full Board. Attachment B shows the Board's typical complaint process including the sanctions the Board is allowed to impose.

In 1989, the Board took 59 disciplinary actions, ranging from entering into Assurances of Discontinuance (AD), to revocation combined with a $10,000 fine (See Attachments C and D). (An AD is the lowest form of reportable discipline. It does not require a physician to admit wrongdoing, but must include a recitation of the underlying circumstances and either a sanction or agreement to pay the costs of the investigation.) The 1989 figure is less than the 85 disciplinary actions the Board took in 1988. The lower figure is due primarily to a regulation regarding physicians with lapsed Massachusetts licenses who have been disciplined in other states. The Board now defers disciplinary proceedings until the physician reapplies for a license. Only three of the 59 final disciplinary orders issued by the Board in 1989 were based upon disciplinary action in another jurisdiction. This represents 5% of all Board discipline, down from 28% in 1988 (See Attachment E).

requirements for physicians, and continued outreach and technical assistance to practitioners and institutions.

Major Incident Reports. Health care facilities and physicians are required by the PCA regulations to report to the Board certain major adverse medical outcomes. Two categories of injuries are reportable:

Category 1: Maternal deaths related to delivery; fetal deaths, excluding abortions; chronic vegetative state resulting from medical intervention; and death in the course of or resulting from ambulatory surgical care.

Category II: Major or permanent impairments of bodily functions or deaths that are not ordinarily expected as foreseeable results of the patient's condition or of appropriately selected and administered treatment.

PCA Unit staff and the two physician members of the Board who sit on the PCA Committee have reviewed every major incident report filed since the reporting requirement went into effect on July 1, 1987. Attachment F summarizes this activity, which included the implementation of new databases and internal control systems aimed at ensuring that every report will be scrutinized by at least one physician, and the development of review criteria designed to determine whether the reporting institution has put into effect appropriate remedial measures following Board examination of the incident.

As Attachment F shows, in the course of the year, 104 major incident reports were filed by health care facilities (87.5 percent of them hospitals) and office-based physicians. By December 31, 111 of the major incident reports filed from 1987 to 1989 had given rise to at least one investigatory letter, and 84 of these investigations were closed after a PCA Committee decision that the facility's response addressed the quality assurance concern highlighted by the incident. In addition, 29 investigations opened in 1988 were closed in 1989.

A typical example of a major incident was an improperly reported lab value that may have contributed to the medical staff's relatively slow response to a elderly patient's decline and ultimate death. Laboratory personnel had assumed that the relevant test had been performed incorrectly and that, therefore, the low lab value was in error (it was not). As a result, staff did not notify the attending physician or retest the patient. Remedial action included counseling of laboratory and nursing staff and revision of daily lab sheets.

In another case, a procedure to repair a fracture was started on the wrong hip. At the Board's request, the hospital revised its operating room admission policy. The policy now explicitly requires three separate staff verifications of the surgical site prior to surgery.

In each of these instances, physician and staff reviewers determined that the remedial measures taken by the health care facility represent a sound risk management solution which is expected to decrease the likelihood that incidents of this type will recur. The files in these cases were closed without further action.

In the past two and a half years, 65 hospitals (44 percent of the total number) have not filed major incident reports of the type reviewed by the PCA Unit and PCA Committee. In August, a letter was sent to non-reporting facilities reminding them of the major incident regulation and describing the Committee's objectives in reviewing incident reports.

In addition to investigation of major incident reports, PCA Unit staff reviewed the two routine reports updating the Board on the internal operation of a health care facility's PCA program. PCA Program Annual and Semi-Annual Reports were filed by hospitals, clinics and mental health centers. Institutions negligent in meeting their filing deadline were reminded on several occasions during the year.

Model PCA Plan for MRI Centers. As with its earlier work with small school and university health services and mental health centers, the PCA Unit developed a model Patient Care Assessment plan for the 16 licensed magnetic resonance imaging (MRI) centers in the

about Continuing Medical Education, the brochure was sent by the medical society to each of its members, and by the Board to each hospital and to hundreds of individual physicians.

Special Projects. During the year, PCA Unit staff worked on several special projects, including the development of a brochure designed to help medical specialty societies develop so-called "specialty standards"--that is, standards or guidelines aimed at improving the quality of medical care which are developed as a result of expert review of closed malpractice claims. (For a more detailed discussion, see Section I.)

In addition, staff completed a report about cardiac monitor alarm systems. The report outlines a potential problem that can arise when alarm devices on cardiac monitors are deactivated, and suggests several potential ways to decrease this risk. The report will be distributed to all acute care hospitals in the Commonwealth.

Finally, staff are beginning to look into the use of low-osmolar contrast media, and, with the assistance of a group of expert radiologists and other health care providers, to examine whether standards can be developed to guide radiologists in the use of this medium. Low-osmolar dye is thought to be safer for certain types of patients, although it is considerably more expensive.

Outreach. In addition to the CME brochure, Unit staff sent news of the new regulatory changes to all affected health care facilities, and spoke at five public forums over the course of the year. These forums included a presentation, primarily on the specialty standards project, to about 20 members of a Massachusetts Medical Society committee in February, and to 30 anesthesiologists at the University of Massachusetts Medical Center in May. Staff also made a presentation on recent regulatory changes to about 25 risk management representatives from the Harvard teaching institutions in July. Board members also contributed their time in presentations to health care facilities and medical and specialty society meetings.

V. DATA REPOSITORY ACTIVITIES

The Board's Data Repository is the central bank for all medical malpractice and disciplinary data in the state (See Attachment G). The Data Repository staff work closely with Board Members serving on the Data Repository Committee to do the following: 1) to ensure that mandated reporters file required information in a timely and complete fashion; 2) to provide contact with national data collection systems that maintain information on individual physicians; 3) to review all statutory reports, identify trends in reports received, and determine which statutory reports shall be investigated by the Disciplinary Unit; 4) to develop policies to follow-up on particular classes of information received; and 5) to assist those studying physician supply issues (See Attachment H).

Closed Claim Reports

The state's four malpractice insurers must file closed claim reports within 30 days after a judgment, settlement, arbitration award or other disposition is reached in a malpractice claim against a physician, regardless of whether payments were awarded. In 1989, the Data Repository received 775 closed claim reports.

Court Reported Malpractice

Court clerks must send copies of complaints and malpractice tribunal findings within 15 days of a finding. Copies of judgments, settlements, or other final dispositions at the trial court level are required to be sent within 15 days of their entry. The Board may keep the identity of the plaintiff confidential. In 1989, the Data Repository received 394 court reports.

Health Care Facility and Nursing Home Disciplinary Action Reports

Health care facilities must file initial, subsequent, and annual reports with the Data Repository that explain disciplinary actions taken against physicians. Facilities must file reports within 30 days after discipline is imposed, follow-up action occurs and final action is taken. The Data Repository received 128 initial disciplinary reports. Twenty-two health care facility reports, pertaining to 21 physicians, resulted in docketed complaints. The Data Repository received 36 subsequent disciplinary action reports.

The Data Repository received one nursing home disciplinary action report in 1989.

Health Care Facility Annual Disciplinary Reports

By statute, hospitals and clinics must file annual summaries of physician disciplinary actions. Summaries must be filed even if no such actions were taken. The reports are due by January 31 for the previous calendar year. For 1989, the Data Repository has received 889 annual disciplinary summary reports.

Government Employee Reports

Government employees engaged in the provision or oversight of any medical or health services must report to the Board when they are aware that a physician has violated either G.L. c. 112, sec. 5 or the Board's regulations. The Data Repository received six government employee reports.

Professional Medical Association Disciplinary Reports

Professional medical associations are required to report disciplinary actions against physicians, regardless of whether the group is local, regional, statewide, national or international. The Board requires that such reports be filed within 30 days of the action. The Data Repository received four professional medical association disciplinary reports involving two reporters in 1989.

Health Care Provider "Snitch Law" Reports

Certain individuals are required to report to the Board when they are aware that a physician has violated either G.L. c. 112, sec. 5 or the Board's regulations. This obligation to report suspected substandard care, impairment, or other possible violations of licensing laws and regulations applies to health care providers, including physicians, dentists, and nurses. The Data Repository received 27 "snitch law" reports in 1989.

VI. LICENSING ACTIVITIES

The Board sets physician licensing standards in Massachusetts. The staff of the Licensing and Examining Unit analyze the documentation associated with the licensing process for physicians. They meet regularly with Board Members serving on the Licensing Committee to review individual license applications and to make recommendations to the full Board. The staff

also administers two licensing examinations each year. The Unit's work is essential to ensuring that only qualified and competent physicians are licensed to practice medicine in Massachusetts.

1989-1991 Birthday Renewal

Physicians with full licenses renew them on their birthdays on a biennial basis. On January 1, 1989, the Board began a new license renewal cycle. The Board revised the 1989-1991 renewal form to provide for more simplified reporting of malpractice and disciplinary histories and to collect better practice pattern information in response to numerous requests for physician supply data. The new form includes code tables so that more accurate and consistent information can be obtained. It is hoped that once the Board has this information in coded form, it will be able to send physicians a computerized, pre-printed renewal application in future years, which the physician will simply correct and update. The total number of renewals processed in 1989 and projected in 1990 is 24,000.

Volume of Other Activities

In addition to license renewals, Licensing Unit staff processed:

1,516 Full, Temporary and Specialty initial license applications;

3,007 Medical Resident and Fellows limited license applications; and

Over 5,000 written verifications of licensure.

Other Licensing Improvements

The Board and its Joint Education Committee (a joint Board and Teaching Hospital Committee) revised the medical resident limited license application forms for both graduates of Foreign Medical Schools and American Medical Schools. In addition, the Committee developed a new form for renewal and/or change of training program.

The Board also computerized the entire medical resident and fellow licensing process so that the process can operate smoothly and the Board can be more responsive to teaching hospital registrars and medical residents. The computerized system (1) tracks all pertinent information; (2) generates lists for Board and teaching hospital use; (3) reports on key dates for renewal and

approval; and (4) prints licenses. It allows staff to examine and modify any record quickly and to answer hospital registrars' questions about any of their medical residents and fellows.

In order to communicate these improvements, two **Licensing Workshops for Hospital Personnel** were held in 1989 (For a description, see Part II).

The Licensing Unit also:

(1) Implemented a mail room computer tracking system for all licensing incoming materials enabling licensing staff to respond quickly to physicians inquiring to see if their documents have been received;

(2) **Simplified** the lapsed license application process;

(3) Issued (in response to requests) inactive status wallet cards to those physicians in inactive status; and

(4) **Simplified** the process for providing information regarding "yes" answers to disciplinary and malpractice questions on the license application.

Licensure Examination

The Board administers the Federation of State Medical Boards licensing examination (FLEX) twice a year. The Federation, through its FLEX Board and in cooperation with the National Board of Medical Examiners, structures and conducts the FLEX examination, the test instrument for medical licensure used by all states and a number of other jurisdictions. In 1989, 139 physicians sat for the examination, 81 in June and 58 in December. The examination is comprised of two components. Component I places special emphasis on fundamental knowledge of the diseases and problems frequently encountered in a supervised setting on an in-patient basis. Component II focuses on a core of critical abilities and knowledge required for diagnosis and management of selected clinical problems most frequently encountered by the physician licensed for the independent, unrestricted practice of medicine.

VII. ACTIVITIES OF THE COMMITTEE ON ACUPUNCTURE

The Board appoints the members of its Committee on Acupuncture which consists of four acupuncturists, one physician with acupuncture experience, one public member, and one physician member of the Board (See Attachment I). The Committee sets regulatory standards for licensure and practice, approves acupuncture schools and training programs, conducts licensure examinations and disciplines acupuncturists who engage in malpractice or misconduct. There are 270 licensed acupuncturists in Massachusetts.

Forms, Systems and Procedures Developed

In 1989, the Acupuncture Unit developed a license renewal application, and administrative procedures for handling the applications. The first renewal applications were sent out in October to licensees renewing in early 1990.

The Unit also developed a temporary license application, and administrative procedures for handling the applications. Other miscellaneous forms were developed to increase efficiency in the Unit and to provide information to licensees and the public.

The Board's Data Management Section together with the Acupuncture Unit designed and implemented a computer system called the Massachusetts Acupuncture Information System (MAIS). The system tracks licensure and disciplinary information on licensees. The Acupuncture Unit compiled a users' manual for the system.

Licensure Examination

The second annual licensure examination was held in June. The examination consisted of a written portion and a practical portion on clean needle technique and sterilization (CNT). The examination is offered in English, Chinese and Korean. In 1989, 17 applicants took the written examination and six applicants took the CNT examination. A total of 46 acupuncturists were licensed during 1989.

Publications

A guidebook on acupuncture laws and regulations was printed and sent to licensed acupuncturists.

Disciplinary Matters

Eighteen complaints were opened on acupuncturists in 1989, fourteen of which were resolved by an Assurance of Discontinuance, dismissal, or other action. The remainder are still in process. One registered acupuncturist was indefinitely suspended from practice for sexual misconduct on the basis of a complaint made prior to 1989.

LIST OF ATTACHMENTS

ATTACHMENT B

THE TYPICAL COMPLAINT PROCESS

The complaint is assigned to a Board INVESTIGATIVE ATTORNEY who contacts the physician and complainant and begins an investigation.

The investigatory file may be reviewed by a member of the Board's *Medical Expert Advisory Panel on Disciplinary Matters.*

⇩

The complaint is presented to the Board's COMPLAINT COMMITTEE which recommends dismissal, an informal conference, a formal hearing, or an Assurance of Discontinuance.

⇩

If the Board agrees that a formal hearing is warranted, it votes a Statement of Allegations which recites the violations of statute and regulation alleged against the physician.

⇩

A Board PROSECUTING ATTORNEY is assigned to write the order, and the physician is asked to "show cause" why (s)he should not be disciplined.

A full adjudicatory hearing before a Board HEARING OFFICER is initiated. Evidence and testimony are presented, and the physician can respond.

⇩

A transcript is prepared, and the HEARING OFFICER makes findings and recommends specific sanctions to the FULL BOARD which can accept, reject, or modify the recommended decision.

⇩

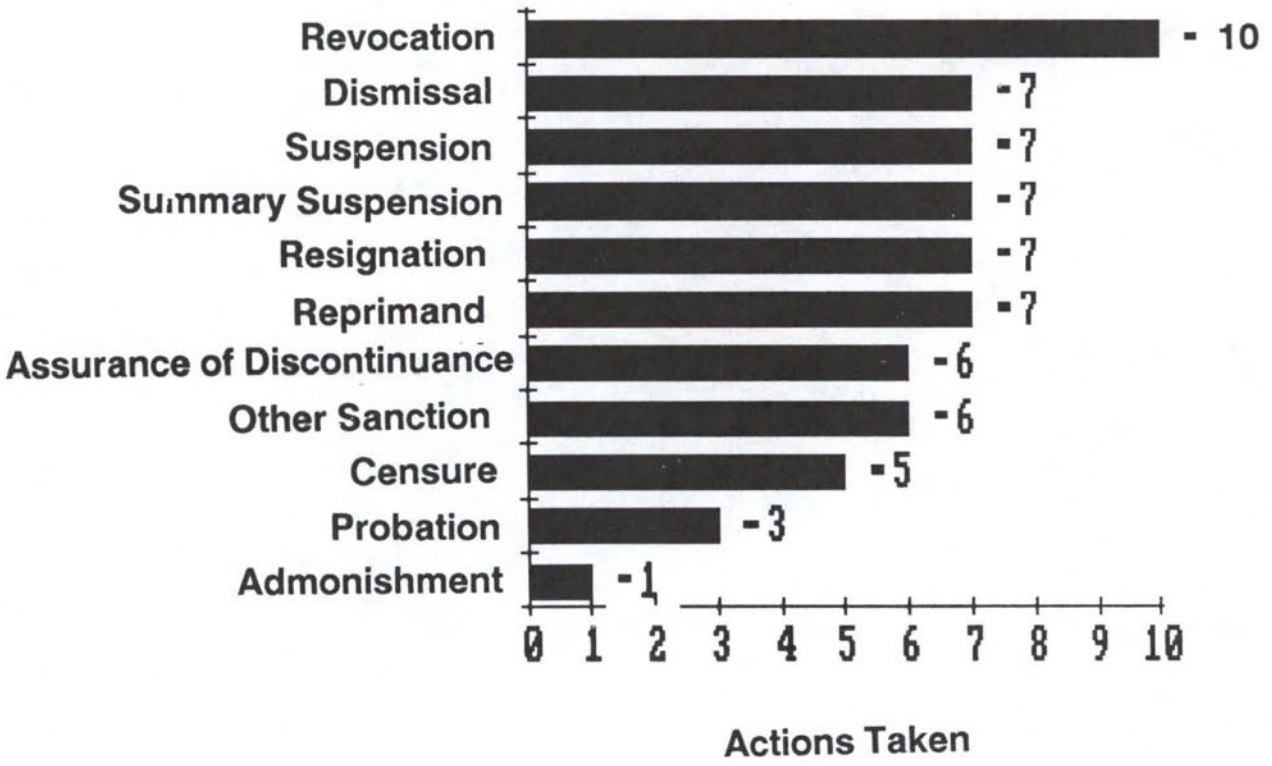
The BOARD issues an order for:

- revocation, suspension, or restriction of license;
- reprimand, censure, or probation (A reprimand is a severe censure);
- up to 100 hours of public service;
- a course of education or training;
- a fine of up to $10,000 for each classification of violation; or
- dismissal of the complaint.

A physician may appeal Board disciplinary decisions to the SUPREME JUDICIAL COURT.

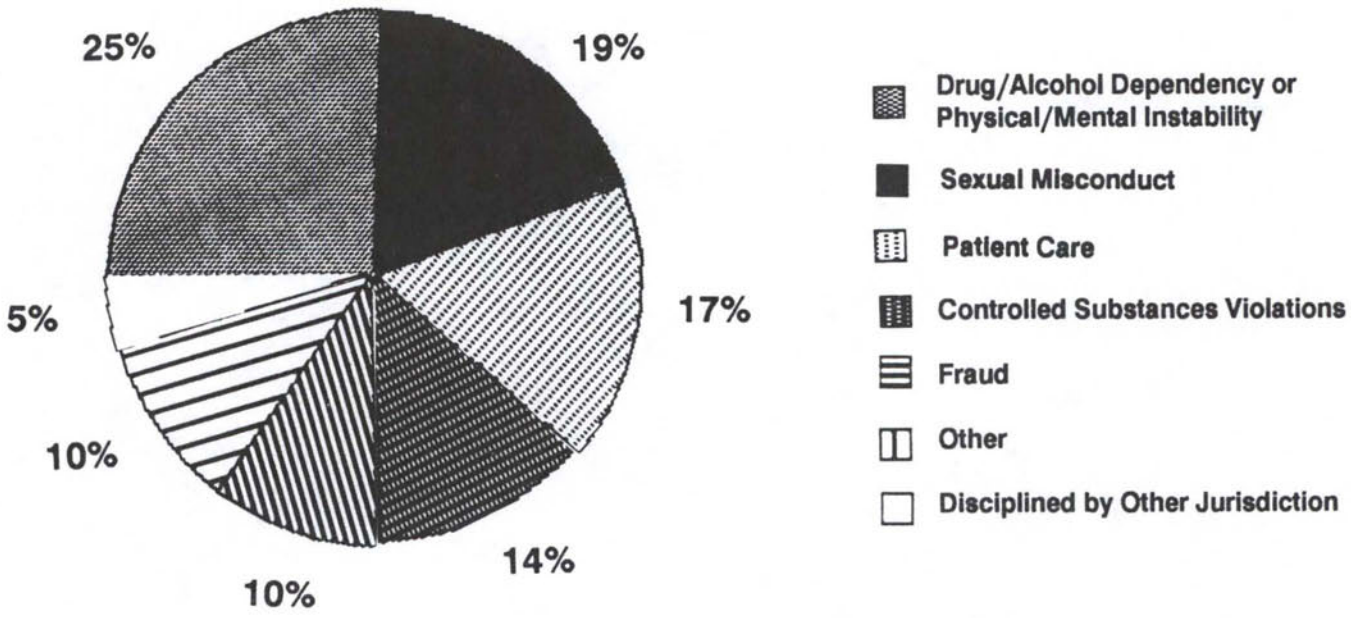
ATTACHMENT C

Breakdown of 1989 Formal Disciplinary Actions



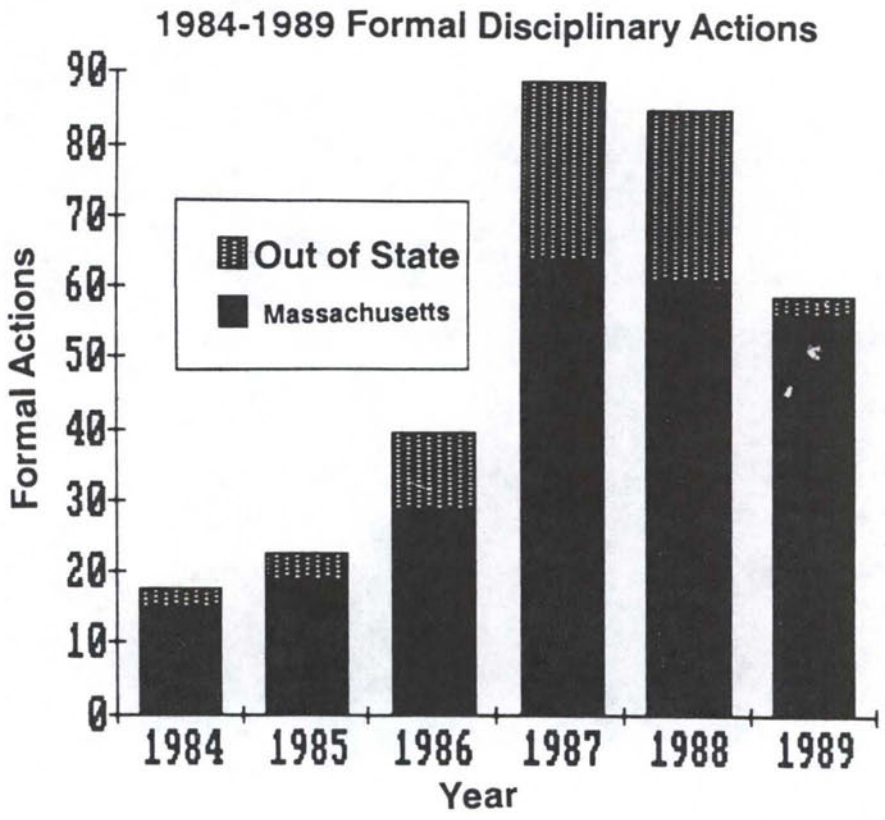
ATTACHMENT D

Reasons for 1989 Formal Disciplinary Actions



1989 Formal Disciplinary Actions (59)

ATTACHMENT E



Summary of Major Incident Report (MIR) Activity

Facility/ (Total #)	Total Number of MIRs Filed[1]			Number of Individual Facilities Filing Reports			Investigations Opened[2]		Investigations Closed		Number of Discrete Facilities Investigated	
	1989	1988	1987[3]	1989	1988	1987[3]	1989	1988	1989	1988	1989	1988
Hospitals (149)	91[4]	142[4]	64	48	53	37	101	40	106	8	43	22
Clinics (48)	2	7	1	1	4	1	2	1	2	1	2	1
Mental Health (121) Centers	8	19	1	3	9	1	5	0	2	0	4	0
Health Maintenance Organizations (20)[5]	0	3	2	0	3	2	2	0	2	0	2	0
Other[6]	3	1	0	3	1	0	1	0	1	0	1	0
Total (year)	104	172	68	55	70	41	111	41	113	9	52	23
Total	344			111			152		122		66	

Explanations and Notes:

[1] As defined in 243 CMR 3.08, except for "other" category. These figures do not include reports filed pursuant to 243 CMR 3.08 (2)(a) 2 (fetal deaths). See footnote 5. Year report is "filed" is deemed to be the year in which the incident occurred. The 1987 figures include one incident that occurred in 1986 and one incident, not reported as a major incident, that occurred in 1984. The 1988 figures include one incident that was not reported as a major incident.

[2] An investigation is opened after an incident is reviewed by the Board's PCA Committee and an investigatory letter sent to the facility. An investigation is closed when a letter is sent to the facility.

[3] All 1987 figures are for the six-month period from July 1, 1987 through December 31, 1987.

[4] In three cases, MIRs were filed by a hospital and a mental health center concerning the same incident; the incident was recorded under the mental health center heading in two of those cases, and under the hospital heading in one of them.

[5] Only staff-model HMOs are subject to the major incident reporting requirement.

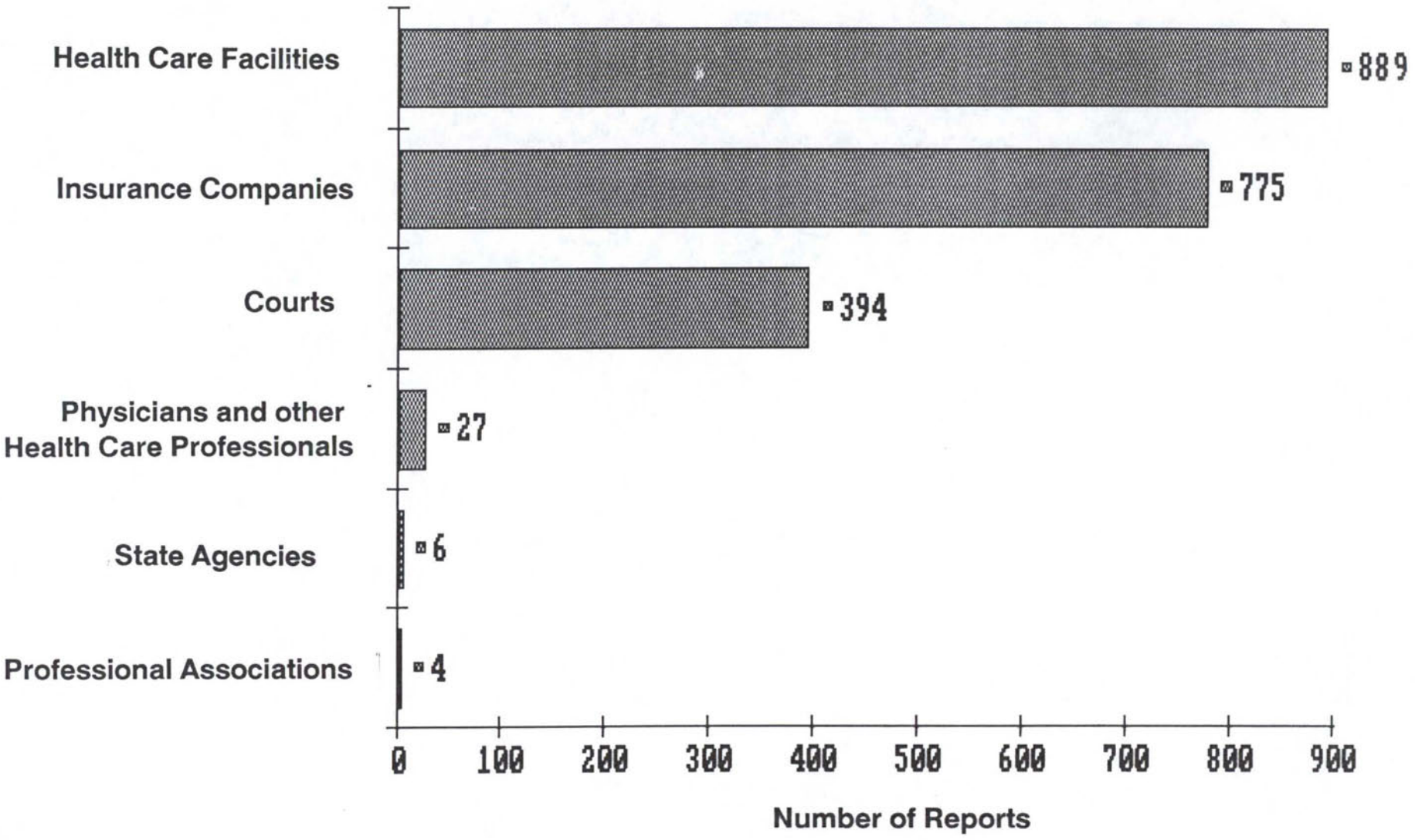
[6] All reports in this category were filed by private office physicians pursuant to 243 CMR 3.11

ATTACHMENT F

ATTACHMENT G

Mandated Reporters

Number of Reports Filed with the Data Repository



ATTACHMENT H

1987-1990 TOTAL PHYSICIAN SUPPLY

Description	**Jan. 1987**	**Jan. 1988**	**Jan. 1989**	**Jan. 1990**
Current Active and Inactive	21,434	20,821	23,302	22,234
Current Active	20,711	19,743	22,216	20,539
Current Active and Business Address in Massachusetts	16,255	15,734	17,180	16,316

Medical Residents with Limited Licenses: 3,007

ATTACHMENT I

Officers and Members of the
Board of Registration in Medicine
Committee on Acupuncture
1989

John G. Myerson,Lic.Ac., Chairman of the Committee
Patricia Leydon, Lic.Ac., Vice Chairman
Marilyn Klashman, Secretary
Kenneth Kin-Fun Chang, Lic.Ac., Acupuncturist Member
Pil Hyun Chun, M.D., Physician Member
Marianne N. Prout, M.D., Physician Board Member
Peter Valaskatgis, Lic.Ac., Acupuncturist Member

Officers and Members
1990

John G. Myerson, Lic.Ac., Chairman of the Committee
Patricia Leydon, Lic.Ac., Vice Chairman
Marilyn Klashman, Secretary
Kenneth Kin-Fun Chang, Lic.Ac., Acupuncturist Member
Pil Hyun Chun, M.D., Physician Member
Donna M. Norris, M.D., Physician Board Member
Peter Valaskatgis, Lic.Ac., Acupuncturist Member

Commonwealth of Massachusetts
Board of Registration in Medicine

Annual Report to the General Court and the Special Commission on Medical Malpractice

Calendar Year 1989